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WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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Committee on Public Health
Representative Chuck Benedict, Chairperson

Statement of Greg Weber, M.S., R.Ph., Chairperson, Pharmacy Examining Board
2009 Assembly Bill 227: Relating to the creation of a prescription drug-monitoring program

Room 400, Northeast, State Capitol, Tuesday, July 28, 2009, 10:00 A.M.

Chairperson Benedict and members of the Committee, my name is Greg Weber. I serve as chair of the Wisconsin Pharmacy Examining Board. Thank you for the opportunity to appear on behalf of the Board.

The Board supports 2009 Assembly Bill 227.

The Board has one recommended amendment to Section 1, 450.19 (2) (a). Rather than list each credential holder authorized to dispense a prescription drug to generate a record, etc., use more general language to indicate all credential holders authorized to dispense must generate a record, etc. Use of general language would capture future credential holders authorized to dispense. For example, 2009 Senate Bill 180, if enacted, would extend "Prescriptive Authority" to qualified psychologists. "Prescriptive Authority" includes dispensing of prescription drugs.

Thank you for the opportunity to appear today.

Aurora Health Care®

ASSEMBLY COMMITTEE ON PUBLIC HEALTH

Representative, Chuck Benedict, Chair

Testimony of Tom Woller
Vice President of Pharmacy Services, Aurora Health Care

2009 Assembly Bill 227
Relating to: directing the Pharmacy Examining Board to create a program to monitor the dispensing of prescription drugs and requiring the exercise of rule-making authority.

Room 400, Northeast, State Capitol
Tuesday, July 28, 2009, 10:00 a.m.

Chairperson Benedict and members of the Committee, thank you for the opportunity to appear on behalf of Aurora Health Care to testify regarding 2009 Assembly Bill 227, which would create a program to monitor the dispensing of controlled substances in Wisconsin. My name is Tom Woller, and I am the Vice President of Pharmacy Services at Aurora Health Care.

The purpose of a Prescription Drug Monitoring Program, (a "PDMP") is to track the prescribing patterns of practitioners for controlled substance prescription orders and to track the names of patients and pharmacy locations from which those patients have those prescriptions filled. The PDMP can theoretically expose over prescribing and/or doctor shopping which may indicate drug diversion.

Drug diversion is generally defined as the possession or use of a controlled substance for a non-medically necessary purpose. A modern style PDMP creates an electronic record whereby a pharmacist or practitioner enters information about a prescription order into a database housed at a state agency. The name of the patient, prescribing practitioner, pharmacy location, drug prescribed and drug amount are typically the core data collected.

Currently, 39 other states have a PDMP, of which 33 are operational. PDMPs can exist for a myriad of reasons. Health departments may use them for trending information for treatment program design and funding estimation. Police and district attorneys have controlled accessed for searching for evidence of crime. Regulatory agencies use PDMPs to reveal practitioners who prescribe large amounts of controlled substances; perhaps indicating indiscriminate prescribing practices.

Aurora Health Care as a provider of medical care to patients recognizes these valid uses of a PDMP but also wants to emphasize that other considerations need to be recognized and addressed regarding how a PDMP is designed and operates in Wisconsin.

Proposed amendments to protect and practitioner liability and patient confidentiality

AB 227 as currently drafted creates a broad set of parameters for the Wisconsin Pharmacy Examining Board to use in designing a system, however, AB 227 is silent in two important respects that we request be considered now, and explicitly included in the legislation.

First, hold harmless protection for providers is needed in AB 227.

All practitioners, pharmacists and pharmacies, recognize that a PDMP is a patient treatment tool that can be used by practitioners to provide better care to their patients. However, a PDMP is not an instrument to interfere with practitioner judgment or a means to create liability for a practitioner in the use of a PDMP. Practitioners, pharmacies and pharmacists need the assurance that they are held harmless in the good faith use of the PDMP.

This hold harmless concept is not new, it is current law

Wis. Stats. Sec. 450.10 (3) (b), of the pharmacy statutes currently has similar language that protects practitioners and pharmacists using and sharing patient confidential information in good faith while providing patient care. That section provides, **civil**, **criminal** and **administrative** liability protection.

- It is requested that an amendment to AB 227 be created, to explicitly maintain the three component good faith protection contained in current law.

If such protection is not extended fully to all three areas, does this signal a change to longstanding law that pharmacists and practitioners will now be treated differently?

Second, patient privacy and confidentiality need to be fully preserved

Wisconsin has also been a leader in the creation of appropriate and balanced patient privacy laws codified in Wis. Stats. Chapter 146, which balance a patient's privacy in his or her medical records with the ability of regulators and law enforcement to access those records.

- Chapter 146 creates an appropriate and well working procedural safeguard that recognizes and balances competing interests. Based upon that current foundation of balancing of rights and access it would be expected that the status quo of Chapter 146, would remain in effect as regarding access to and use of a PDMP.
- The original draft of AB 227 is not clear with how the PDMP will be accessed and by whom, and implies that the Wisconsin Pharmacy Examining Board could draft rules allowing access in ways other than provided by Wis. Stat. Ch. 146.
- We request that an amendment be drafted to clarify that Wis Stat. Ch. 146, still controls access to patient health care records in the PDMP context.
- The access issue has one main component, and it is whether or not law enforcement will be able to obtain access to the PDMP to investigate patients or providers without a court order. Current Ch. 146 would not allow that.
- Some proponents of a PDMP for Wisconsin may want to eliminate that protection.
- We believe that Ch. 146 works properly for the citizens of Wisconsin and has done so for years. It provides the basic framework for many types of law enforcement and regulatory agencies to obtain access to patient records for many purposes, law enforcement being one subset.

- This issue is so important that it should not be left to the Pharmacy Examining Board to even be debating whether it has the power to contradict Ch. 146, or whether it is even wise to do so.

We believe the better course is to be explicit in AB 227 that the full protections of Ch. 146 apply, as would be expected.

With these two additional considerations addressing practitioner liability and patient privacy, AB 227 can provide a framework going forward to create a PDMP for the citizens of Wisconsin that will enhance public safety and promote better patient treatment.

Thank you for allowing me to appear today to share Aurora Health Care's perspective on 2009 AB 227.

I would be glad to answer any questions that you may have.

To: Assembly Public Health Committee July 28, 2009

From: Darold A. Treffert, M.D. Chairman, Wisconsin Controlled Substances Board

Re: Assembly Bill 227

I am Darold Treffert, M.D. from Fond du Lac, Wisconsin, psychiatrist member and chairman of the Controlled Substances Board (CSB). I am here in support of AB 227 on behalf of the CSB which on June 4, 2009 unanimously passed such a motion. A letter to Representatives Sherman and Townsend conveying that support is attached.

Abuse of prescription controlled drugs is a major problem throughout the United States; it has been such for many years among adults, particularly with pain medications. DEA reported that in 2006 7 million Americans were abusing pain, tranquilizer, stimulant and sedative prescription medications. In 2005 there were 8500 prescription drug abuse related overdose deaths according to the Office of National Drug Control Policy. Even more urgently, that problem is escalating rapidly, especially among adolescents, young adults and even children wherein such diverted prescription medications have caused increasing drug dependency, overdose and death even in these age groups. As a partial response, by November 2008 thirty-eight states had in place Prescription Drug Monitoring Programs (PDMP) and eleven states were in the process of implementing such programs. With 49 states actively involved in such programming, it leaves only Wisconsin and the District of Columbia as jurisdictions without such programs.

PDMP programs do work. By permitting prescription tracking one can detect illicit diversion and doctor shopping, two large contributors to controlled-substance prescription drug abuse. Some programs have reported as much as a 30% reduction in such activities already. Additional evidence that prescription tracking works comes from the CSB itself here in Wisconsin when a 1976 project tracking purchase at a retail level of bi-phetamine 20 (black Cadillac's) was able to identify specific practitioners who were diverting this product. Eventually the "amphetamine rule" was put into effect in Wisconsin and the prescription of Bi-phetamine 20 dropped 97%. Subsequently nearly every other state followed that Wisconsin model.

As you will see in the letter attached, the CSB suggested that instead of listing practitioner categories that would be required to comply with the documentation and delivery requirements in the bill, language such as "practitioners dispensing for human use" would cover all present and future practitioners with such prescribing privileges rather than having to amend the bill each time some new group might be given prescriptive authority in the future. This would also preclude inclusion of veterinarians which we assume was the intent of the legislation.

Obtaining the grant of course is the first order of business. When it comes time to implement a PDMP program through the Pharmacy Examining Board, which this bill contemplates, the CSB stands ready to help in the design of any such program based on its long experience with, and stake in, the controlled substances prescription diversion problem. Hopefully grant funds will become available. If not this bill's provisions are moot. In such an instance I would hope that alternative mechanisms to put in place a PDMP in Wisconsin would be explored, given the urgent need for such prescription and dispensing tracking in our state.

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June 9, 2009

THE HONORABLE GARY SHERMAN
STATE REPRESENTATIVE
ROOM 304 EAST
STATE CAPITOL
P.O. BOX 8953
MADISON WI 53708

THE HONORABLE JOHN TOWNSEND
STATE REPRESENTATIVE
ROOM 22 WEST
STATE CAPITOL
P.O. BOX 8953
MADISON WI 53708

Re: Assembly Bill 227, relating to directing the Pharmacy Examining Board to create a program to monitor the dispensing of prescription drugs and requiring the exercise of rule-making authority

Dear Representative Townsend:

The Wisconsin Controlled Substances Board reviewed 2009 Assembly Bill 227 at its meeting on June 4. The Board supports the intent of the bill since it would join Wisconsin with other states that already have such programs in place for the detection and tracking of the serious problem of prescription drug diversion. By unanimous motion, the Board agreed to suggest an amendment to Section 1, 450.19 (2) (a), which lists practitioners who would be required to comply with the documentation and delivery requirements in the bill. The Board believes that instead of a listing of specific practitioner categories, language such as "practitioners dispensing for human use" (to clarify it does not apply to veterinarians) would be preferable in view of the possibility of the list of practitioners changing or expanding over time. If listed specifically, each time there might be a change in types of practitioners included, separate legislation would be required. For example Assembly Bill 180 proposes to grant dispensing authority to psychologists and, if enacted, AB 227 in its present form would not include psychologists. The use of the alternative language suggested would make it certain that all categories of practitioners authorized to dispense a prescription drug for human use would be included in the present and future provisions of AB 227. The alternative language excludes dispensing of prescription drugs by veterinarians from the tracking provisions of AB 227 which we presume was the intent of the legislation.

Sincerely,

Darold Treffert, M.D.
Chair, Controlled Substances Board

c: Representative Gary Sherman

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Assembly Committee on Public Health

FROM: Mark Grapentine, JD – Senior Vice President, Government Relations

DATE: July 28, 2009

RE: Information on Assembly Bill 227

On behalf of nearly 12,500 members statewide, the Wisconsin Medical Society thanks you for this opportunity to share information on Assembly Bill 227, which would direct the Pharmacy Examining Board to create a prescription drug monitoring program (PDMP). The Society believes the bill could be improved via further amendments, which if adopted could allow the Society to offer its support for AB 227.

The Society very much supports the basic goals of creating a PDMP, including the ability to identify "doctor shopping" patients who seek narcotics and other prescription drugs. The American Medical Association (AMA) has policy directly on point, albeit with a scope wider than the borders of a single state:

> **H-95.947 Prescription Drug Monitoring to Prevent Abuse of Controlled Substances**
> Our AMA:
> (1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
> (2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
> (3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interaoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
> (4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions; and
> (5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians. (BOT Rep. 3, A-08)

As the AMA policy shows, there are at least two important issues underlying the creation of a PDMP: privacy laws and due process safeguards related to potential liability for health care professionals making good-faith efforts to comply with a PDMP.

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Liability
Assembly Amendment 1 to Assembly Bill 227 currently adds civil immunity protection for good faith compliance with the bill or subsequent rules promulgated following the bill's enactment (AA1 to AB 227, page 2, lines 4-10). The Society believes that any bill creating a PDMP should also include criminal and administrative protections for health care professionals making the same good-faith compliance efforts.

Broader protections would be consistent with current law. Statutes affecting the Pharmacy Examining Board already anticipate the need to provide these broader protections for health care professionals complying with the myriad of laws affecting prescription drugs:

> (b) Any health care professional who in good faith provides another health care professional with information concerning a violation of this chapter or ch. 961 by any person shall be immune from any civil or criminal liability that results from any act or omission in providing such information. In any administrative or court proceeding, the good faith of the health care professional providing such information shall be presumed. (WIS STATS s. 450.10(3)(b))

The Society believes that the primary goal of a PDMP should be adding a tool for a health care professional to provide optimum care for the patient. Restricting liability protections as seen in other areas of the law speaks to the potential that a PDMP might be created for a different purpose. The Society offers to continue to work with the authors of AB 227 to improve the bill in this important area.

Privacy
Finding a balance between a patient's privacy rights over medical records and the ability of regulators and law enforcement to access patient records is a constant tension in today's health care world. Wisconsin has been a leader in this area through enactment of various requirements in ch. 146 of the state statutes, related to health care records privacy.

It is not entirely clear how AB 227 as currently drafted would impact the important confidentiality requirements of WIS STATS s. 146.82 and s. 146.83. Any bill creating a PDMP should ensure that new statues or administrative rules creating the program comply with – rather than chip away at – requirements under current law. Rather than leave some of these admittedly complex questions to the rulemaking process, we believe that the bill should more specifically enumerate interaction with ch. 146.

Other Issues
Other issues of importance include:

- How health care professionals not currently using an electronic medical records system will be able to comply with the requirements of the PDMP. While the health care world moves toward greater use of electronic record-keeping every year, not every health care practitioner in the state enjoys the infrastructure provided by a larger system. A new PDMP requirement could prove onerous.
- How a PDMP will add to the ability of the Medical Examining Board to protect the public and improve the practice of medicine. The MEB is continuing to evolve, and may have additional capacity to identify and rectify potentially troubling practices.

Thank you again for this opportunity to provide our thoughts on AB 227. If you have any questions on this or any other issue, please feel free to contact me at any time.

To All:

I have provided a link in this week's legislative newsletter (below) about the prescription drug monitoring program legislation that is currently being circulated for co-sponsorship by Reps. Sherman and Townsend. The bill language included in the newsletter is the language that has been sent to Capitol offices; however, earlier today I had a conversation with Rep. Sherman's office about a very necessary amendment. When I was drafting the PSW Capitol memo, it occurred to me that the legislation doesn't include any liability protections for health care providers; liability protection for health care providers has been included in every PDMP in every state. I requested that Sherman's office inquire with Legislative Council to verify there is language in the bill? I also asked for an amendment if such language was absent.

Here is the response from Rep. Sherman's office:

There are no liability protections built into the bill as currently drafted. I spoke with the drafter and he gave me language from Minnesota, which I've copied below. Let me know if this is the type of thing you are looking for or if you have some other model(s) that you'd like me to share with Gary.

Thanks,

Joe

Joseph P. Hoey
Office of Rep. Gary Sherman
74th Assembly District
(608) 266-7690 / (888) 534-0074

Subd. 9.Immunity from liability; no requirement to obtain information.

(a) A pharmacist, prescriber, or other dispenser making a report to the program in good faith under this section is immune from any civil, criminal, or administrative liability, which might otherwise be incurred or imposed as a result of the report, or on the basis that the pharmacist or prescriber did or did not seek or obtain or use information from the program.

(b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser to obtain information about a patient from the program, and the pharmacist, prescriber, or other dispenser, if acting in good faith, is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.

Tom Engels
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Testimony of
Arthur Thexton
President
Wisconsin Chapter
National Association of Drug Diversion Investigators,
before the
Assembly Committee on Public Health
Hearing on AB 227
July 28, 2009

Good morning, thank you for the opportunity to testify regarding this important matter.

I am Arthur Thexton, President of the Wisconsin Chapter of the National Association of Drug Diversion Investigators. NADDI is an organization which brings together law enforcement and regulatory staff from the local, state, and federal levels, together with private security staff from the pharmacy industry, all for the purpose of improving investigation, and prevention, of diversion of pharmaceutical products. NADDI was organized 20 years ago and conducts training in diversion investigation, and public education and advocacy, across the United States.

My own background includes being a sheriff's deputy, an elected district attorney, and, for the past 18 years, a prosecutor for the Department of Regulation & Licensing, where I have handled most of the impairment, diversion, and inappropriate prescribing cases involving physicians and other health care providers, for most of those years, including having been the principal prosecutor for the Pharmacy Examining Board for over a decade. However, I am on vacation time today, and am not speaking on behalf of the Department or any of its attached Boards. I am appearing solely on behalf of NADDI and as a private citizen.

NADDI has long advocated for states to enact Prescription Drug Monitoring Programs, and these are now enacted in 2/3 of the states, including all of the largest states, and cover the overwhelming majority of the population. All of our neighbors have enacted legislation authorizing these programs, and, under federal funding requirements, they will be required to "talk" to each other.

These programs serve two important functions: they enable prescribers, such as physicians, dentists, nurse practitioners, podiatrists, and physician assistants, to check on persons presenting themselves as patients, to determine whether they have received controlled substances from others. It is a sad fact that there is a group of entrepreneurs who pose as patients for the purpose of obtaining inventory, by lying to prescribers and faking symptoms. This tool will enable prescribers to detect these persons, and avoid becoming unwitting enablers.

At the same time, this tool will allow law enforcement to quickly learn the location of evidence in cases involving these "doctor shoppers." At present, law enforcement must visit all of the individual non-chain pharmacies in an area, to determine whether a person is doctorshopping; this is a huge expenditure of staff time and resources. Being able to query a central database in a few minutes, electronically, will save hundreds of hours of time, and miles on the road. This is especially significant when we must all learn to do our jobs more efficiently. This feature will also assist those of us regulators responsible for licensing investigations, in the same way.

The current proposal locates the program in the state pharmacy examining board. NADDI has no position on where the program should be located, as long as it is accessible to those with legitimate needs for the data.

There are legitimate privacy concerns whenever government assembles a database on citizens, and this is certainly true when medical information is involved, as it is here. NADDI advocates for pain patients, and opposes proposals which seek to prevent legitimate prescribing for legitimate patients. We recognize that it is very difficult to distinguish between people who are lying about their pain, and those who are telling the truth. Just because a person is receiving controlled substances for pain or other legitimate medical condition, does not make that patient a diverter, or the prescriber a criminal. All PDMP's have safeguards against fishing expeditions, and we anticipate that Wisconsin's will also incorporate appropriate privacy safeguards, including requirements that all queries be accompanied by a certification that there is a pre-existing investigation of the person whose data is being sought.

You may hear suggestions that law enforcement, or we at the Department, will start using the database to conduct searches to see who is prescribing the most, or who is using multiple prescribers, proactively. This is seen by many as a civil liberties problem. I can tell you that this is not a problem which is likely to develop.

Again, I am not speaking on behalf of the Department or its Boards, but I can tell you from my 18 years of experience that ours, and all regulatory agencies, and all law enforcement agencies, are complaint driven. We are all overwhelmed with cases, and already lack staff and resources to investigate all the complaints we presently receive; we don't have the time to go looking for cases about which no one has complained. So, as a practical matter, fishing expeditions or other inappropriate uses of the system are highly unlikely, and will also be prohibited by any rules adopted by the agency which houses the program, as they are in every other state.

These kinds of monitoring programs are, in today's society, essential to preventing and solving drug diversion, they are in effect in most of the United States, and Wisconsin is now an island surrounded by states which have, or are getting, this kind of program. We cannot afford to become an island, where drug diverters come to get prescriptions because we cannot detect them. On behalf of NADDI-Wisconsin, and as a prosecutor of many years experience in this area, I strongly urge the committee to adopt this, or a very similar, measure.

Again, thank you for the opportunity to testify here, today. I would be happy to answer any questions.

Arthur Thexton
President, NADDI—WI
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2142 E. Johnson St. #2
Madison, WI 53704-4710

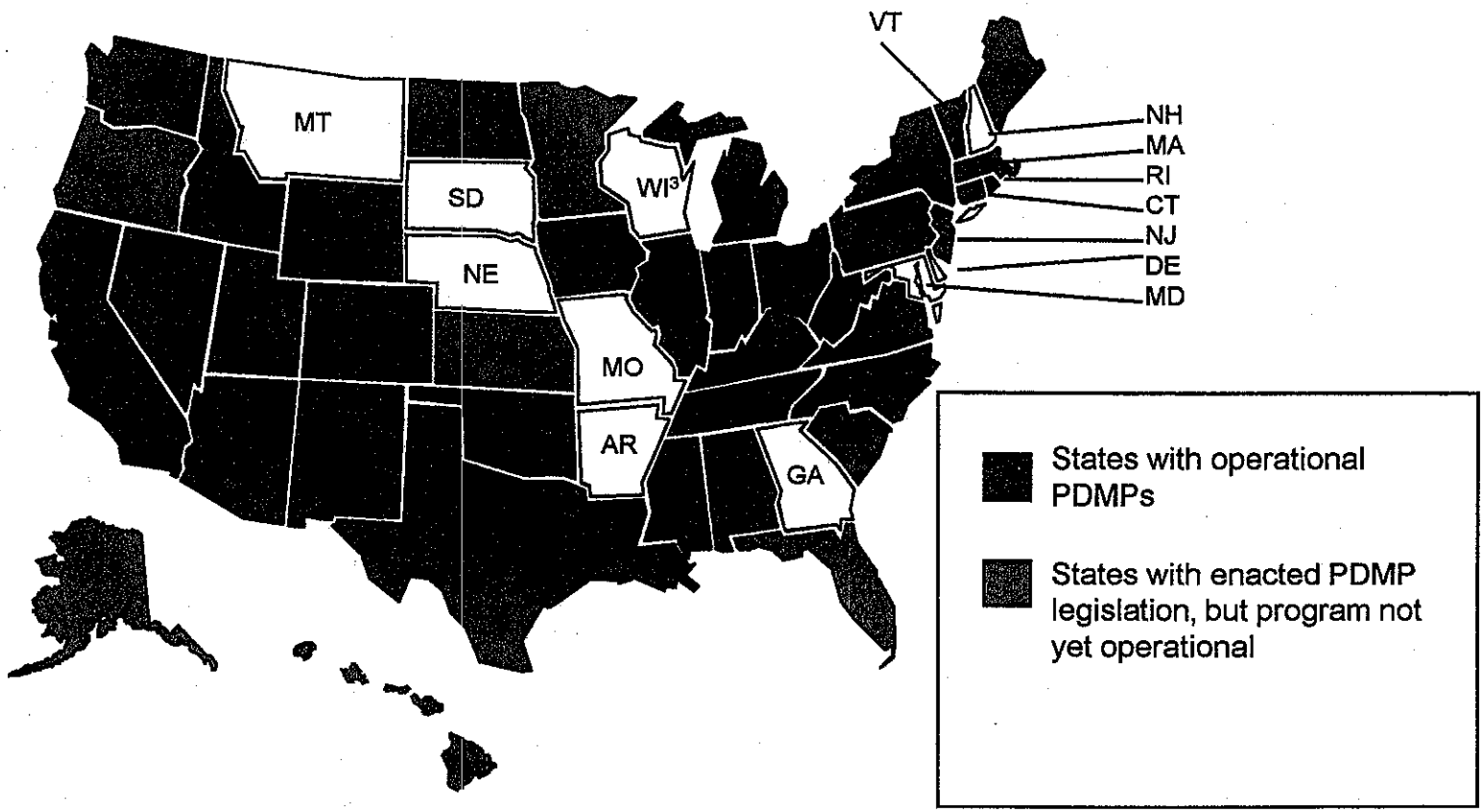
Status of State Prescription Drug Monitoring Programs

Please note: The National Alliance for Model State Drug Laws defines an "operational" Prescription Drug Monitoring Program as a program that is currently collecting prescription data and can respond to requests for reports by those authorized to make these requests.

States	PMP	Status of Enabling Legislation
Alabama	Operational	Enacted
Alaska		Enacted
Arizona	Operational	Enacted
Arkansas		
California	Operational	Enacted
Colorado	Operational	Enacted
Connecticut	Operational	Enacted
Delaware		
District of Columbia		
Florida		Gov. Sig. Pending
Georgia		
Hawaii	Operational	Enacted
Idaho	Operational	Enacted
Illinois	Operational	Enacted
Indiana	Operational	Enacted
Iowa		Enacted
Kansas		Enacted
Kentucky	Operational	Enacted
Louisiana	Operational	Enacted
Maine	Operational	Enacted
Maryland		
Massachusetts	Operational	Enacted
Michigan	Operational	Enacted
Minnesota		Enacted
Mississippi	Operational	Enacted
Missouri		Pending
Montana		
Nebraska		
Nevada	Operational	Enacted
New Hampshire		
New Jersey		Enacted
New Mexico	Operational	Enacted
New York	Operational	Enacted
North Carolina	Operational	Enacted
North Dakota	Operational	Enacted
Ohio	Operational	Enacted
Oklahoma	Operational	Enacted
Oregon		Pending
Pennsylvania	Operational	Enacted
Rhode Island	Operational	Enacted
South Carolina	Operational	Enacted
South Dakota		
Tennessee	Operational	Enacted
Texas	Operational	Enacted
Utah	Operational	Enacted
Vermont		Enacted
Virginia	Operational	Enacted
Washington	Operations Suspended	Enacted
West Virginia	Operational	Enacted
Wisconsin		
Wyoming	Operational	Enacted
	33	38 enacted; 3 pending

Research is current through 5/11/09. To ensure information herein is as current as possible, research is conducted using legislative research software and individual state legislative websites. Please contact Sherry Green at 703-836-6100 ext. 116 or at sgreen@namsdl.org with any additional updates or information that may be relevant to this document. Headquarters Office: THE NATIONAL ALLIANCE FOR MODEL STATE DRUGS LAWS (NAMSDL). 1414 Prince Street, Suite 312, Alexandria, VA 22314.

Status of State Prescription Drug Monitoring Programs (PDMPs)



[1]Washington has temporarily suspended its PMP operations due to budgetary constraints.
[2]The Oregon Legislature has passed legislation to establish a PDMP, which will become effective upon the Governor's signature.
[3]Legislation has been proposed in Wisconsin that ,if passed, would establish a PDMP.

OFFICE OF
DODGE COUNTY SHERIFF

TODD M. NEHLS
Sheriff

BLAINE LAUERSDORF
Chief Deputy

Rep. Gary Sherman
PO Box 8953
Madison WI 53708

Friday, July 24, 2009

RE: Wisconsin, AB 227

Dear Rep. Sherman,

My name is Detective Brian Drumm and I work for the Dodge County Sheriff's Department. In 2005 I handled a case at Dodge County Institution where an incarcerated inmate had become so dependant on prescription pain killers, that he gave direction to his wife to hide these drugs in the pockets of his infant son when the child came to visit him at the prison. Letters sent out with these instructions were intercepted by institution staff, and lead to me waiting for the child with a search warrant. On the day of the interdiction, the child was being carried into the institution by the paternal grandmother who was in on the conspiracy, and the drugs were discovered in the infant's front pocked. As a father I know that it is a natural instinct for an infant to put everything in their mouth. If the infant had discovered these medications, well let's just be thankful that I got them before anyone else.

Some time after this investigation I was asked what type of drug investigations I would be willing to assist on. My personal experience with this case, more than any other, prompted me to become involved in investigating diverted prescription drug cases in Dodge County. In 2006 I joined the Dodge County Drug Task Force to work as the primary investigator of Prescription Drug Diversion cases. Since that time I have seen the tragic consequences that are associated with young and old who take these medications outside of the medical application.

The "typical" case in Dodge County consists of an addict going to multiple doctors complaining of the same symptoms. Doctors are chosen to make sure that they are not a part of the same medical group so that they have no way of checking any computerized file to determine who else the patient is seeing. When the patient is asked if they are seeing any other doctors, they simply say "No" and the Doctors have no way of knowing if this is the truth or not. Once the desired prescriptions are obtained they are taken to different pharmacies.

A health insurance company will not approve multiple prescriptions for the same drug. Or the addict may not have insurance at all which will force them to pay cash for the prescriptions they desire. The easies way to come up with this cash is to sell some of the prescription for as much as one dollar ($1.00) per milligram depending on the type of drug. If you are getting 40 mg Oxycodone tablets, it is not hard to do the math and come up with a substantial profit to be made.

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The only way to make a substantial impact in this growing problem is by implementing a Prescription Drug Monitoring Program so that Doctors and Pharmacists can see what medications a patient is already taking, before the begin a new regiment of drugs.

I recently asked the Dodge County Medical Examiner to give me a ball park estimate of how many deaths a year he believes are directly attributed to prescription drugs, or a combination of prescription and street drugs. He estimated that there have been fourteen deaths (14) per year for the last two years.

Obviously these numbers are not acceptable, and any help would be greatly appreciated.

Respectfully,

Detective Brian Drumm
Dodge County Sheriff's Department
(920) 386-3748 Desk
(920) 386-3254 Fax

bpd

Red Cliff Band Of Lake Superior Chippewa

"The Hub Of The  Chippewa Nation"

RED CLIFF TRIBAL COUNCIL

Good morning and on behalf of our Chairperson Rose Soulier and the Red Cliff Tribal Council I want to thank you for this opportunity to speak about this most important issue. My name is Charles Bresette and I am the Chief of Police for the Red Cliff Band of Lake Superior Chippewa Indians. We are a small, impoverished Tribe located on the northernmost tip of Wisconsin. Like many economically-depressed areas, the drug abuse in our community is especially common and above the nationwide average. Over the past decade, the problem of prescription drug abuse has become prevalent. Prescription drug abuse presents dangers not only to the abuser, but also to the abusers family. Prescription drug abusers, like those who abuse non-prescription drugs, sometimes engage in violent behavior, neglect the safety of children within their care, operate motor vehicles under the influence, and otherwise present dangers to society at large.

Complicating matters, the confidential nature of the relationship between health care providers and those who abuse prescription drugs has hampered our ability to combat this type of crime. At Red Cliff, our direct experience dealing with the issues surrounding the abuse of prescription drugs led us to seek out new methods to combat this type of crime. In March of this past year, some of these issues came to a head in connection with contact from our own physicians as well as other law enforcement agencies seeking to address specific instances of suspected criminal activity. Rather than wait for assistance from outside entities, we decided to attempt to address these issues ourselves as best we could. This led to our own internal policy at the Red Cliff Community Health Center entitled "Controlled Substance Prescribing Policy." Within our own internal policy we took measures such as:

► restricting the ability of those who are prescribed medications to have their medications replaced upon their claim that it had been lost, stolen, damaged or destroyed

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► requiring that the patient present original containers with remaining medications to each office visit

► unannounced pill counts; and

► reserving the right to cancel prescriptions upon receipt of evidence that the patient's medication or a similar medication is being prescribed by an outside provider

On April 7, 2008 the Red Cliff Tribal Council passed Resolution No. 04-08-2008CC which supports the establishment of an online Prescription Monitoring Program in the State of Wisconsin which would be available to providers who write prescriptions for controlled substances and which allow networking with databases of adjacent states.

We have been a member of the Chequamegon Bay Area Prescription Drug Abuse Task Force for the past 5 years and this task force main focus is to talk with other law enforcement agencies as well as health care providers about solutions to the problem of prescription drug abuse and diversion. Throughout all of our efforts, a central theme has emerged: The need for a central data base to stop the diversion and abuse of prescription drugs. We have discussed this issue directly with our representative Gary Sherman, and are fully supportive of the Bill that he has introduced AB 227 which directs the Pharmacy Examining Board to create a program to monitor the dispensing of prescription drugs. The requirement that those who dispense prescription drugs maintain records documenting dispensing of those drugs will assist law enforcement efforts by making this information available to law enforcement upon appropriate court order and will track efforts being made at the federal level to address this most important issue. We urge you to pass AB 277 and to pledge your full support to the ongoing efforts of law enforcement to make our communities a safer place. Thank you for taking the time to listen to our concerns.